Community Mental Health Association of Michigan

CMHA FY26 Appropriations Key Issues

MEDICAID RATES MUST BE ADDRESSED

- **CMHA members faced a $45-50 million Medicaid shortfall for FY24**. The attempted rate adjustments from MDHHS throughout FY24 we not able to keep up with the dramatic drop in Medicaid enrollment last year.
    - Our members receive a payment for every person enrolled in Medicaid regardless if we see them or not. The more people the more payments (and the smaller the payment would be), but as people starting losing their coverage during redeterminations our members lost those payments, when that occurs the payments we receive must grow in order for the system to have adequate funding to provide the services and supports required. In FY24 those payments did not grow fast enough which caused the Medicaid shortfall.

    - **NO NEW MONEY WAS NEEDED IN FY24 – the FY24 Medicaid Mental Health line item was under spent by $37.4 million and the Health Michigan behavioral health line item was under spent by $125.6 million.**

- The projected FY25 trends look worse than the FY24 numbers. **If rate adjustments do not occur our members are facing a $232 million shortfall in FY25.**

    - **The projected under spending in Medicaid Mental Health is $216.4 million and the Health Michigan behavioral health will be under spent by $71 million.**

    - **Rates must also be adjusted to reflect increasing employer costs.**
        - FY25 rates must address increased employer costs. Over the past two years PIHPs and CMHs needed to address increased wages, signing bonuses and increased provider costs to recruit and retain staff.
        - FY25 rates must address legislative changes to unemployment benefits (increasing the number of weeks and the weekly maximum benefits)
        - FY25 rates must address legislative changes to minimum wage and earned sick time act (ESTA)
        - FY25 rates must address mandated provider increase adopted by the legislature for ABA and methadone services.

426 S. Walnut St. • Lansing, MI 48933 • (517) 374-6848 • Fax (517) 374-1053 • www.cmham.org

IDENTIFYING AND ADDRESSING THE CAUSES OF THE UNEXPECTED MOVEMENT OF DISABLE AGED AND BLIND (DAB) ENROLLEES TO OTHER MEDICAID CATEGORIS

- **It is equally important that people get slotted into the "correct" Medicaid bucket.** The state's PIHPs and CMSHPs are seeing unusual re-enrollment patterns. The movement of formerly DAB beneficiaries to other Medicaid categories, has dramatically reduced the revenue expected and needed by the state's PIHPs.
- **Thousands of DAB beneficiaries were put into another Medicaid program in FY24 during redetermination.**
    - Reimbursement for Medicaid programs:
        - DAB - $377/per person – per month
        - Healthy Michigan - $54 / per person – per month
        - TANF - $29 / per person - per month
        - Plan First - $0

- in FY 2024, the **number of lost DAB months jumped by 182%.** The bulk of this increase was caused by the movement of DAB beneficiaries to the Plan First, which offers NO Mental Health benefit.

- **This movement from DAB to TANF, HMP, and Plan First is out of the ordinary given that persons in the Disabled, Aged, and Blind (DAB) Medicaid program have, in the main, conditions that are chronic and, in most cases, lifelong**

- **The loss in revenue to the Prepaid Inpatient Health Plan (PIHP) system in FY24 alone was over $300 million due to beneficiaries being enrolled into an inappropriate Medicaid bucket.**

CONTINUED PHASE OUT OF LOCAL MATCH DRAW DOWN – SECTION 928

- FY26 budget to include $5 million GF/GP to offset local/county resources for Medicaid match purposes and continue the 5-year phase out of the use of local/county dollars for Medicaid match purposes.

    - This was not included in the final conference report for FY24, which should have been year 4 of the 5-year phase out.

- Language from FY23 budget:

    - (3) It is the intent of the legislature that the amount of local funds used in subsection (1) be phased out and offset with state general fund/general purpose revenue in equal amounts over a 5-year period.

BETTER COORDINATION WITH MENTAL HEALTH IN SCHOOL FUNDING

The FY26 Executive Budget recommendation includes $258 million for student mental health and school safety needs. The budget supports districts in managing individualized mental health needs and enhancing the safety of school buildings.

- **CMHA suggests taking a collaborative approach with the school mental health resources. The solution lies not in isolated efforts but in a collaborative integrated approach** — one that encourages all of Michigan's school districts, as many have done, to partner with community mental health agencies and use their school-based mental health financing and related resources to contract for a range of mental health services from the state's community mental health system.
    - **How we can break down the existing walls between schools and community mental health organizations, and build a more seamless, resilient system that serves all students more effectively.**

OPPOSE FUNDING WASKUL LAWSUIT

Reject the settlement deal and force plaintiffs back to negotiations to create a more balanced resolution.

- On December 1, 2023, a signed settlement agreement between Plaintiffs and Defendant MDHHS was filed with the Court.
    - The plaintiffs contend that the dollars provided to these plaintiffs, as part of a Self Determination/Self-Directed Budget arrangement, are insufficient to recruit and retain Direct Care Workers, providing Community Living Supports (CLS), to support the plaintiffs in their homes and community.
        - The plaintiffs were receiving $21/hour to hire staff to provide CLS services for their loved ones. (average Direct Care Workers earns around $16.50/hour)

- **What the lawsuit ordered:**
    - A minimum $31 per service hour rate for all self-determination CLS recipients served by Michigan's Habilitation Supports Waiver is estimated to represent an additional annual expenditure of $22.1 million, a 34.7% increase over the base year (FY2021) expenditure of $63.1 million.
        - There are 50,000 direct care workers in the mental health system, this lawsuit impact around 7% of those workers

- Assuming implementation by the start of Fiscal Year 2025 in October 2024, the additional spending mandated by the agreement will exceed $100 million, even without taking into account additional agreed upon expenditures for Overnight Health and Safety Supports.

- In order for this agreement to go into **effect the court must rule in favor (which it did January 2025), CMS must approve (has not happened yet), the LEGISLATURE MUST APPROPRIATE THE FUNDS, and PIHPS must sign a contract (5 of the 10 PIHPS have NOT)**

- **If this lawsuit is approved and if plaintiffs continued to sue and expand this to all direct care workers this has the potential to cost the state of Michigan between $1 – 2 BILLION.**
    - **For every $1/hour you increase direct care workers (50,000 in public mental health system and 50,000 in long term care) it costs the state over $200 million.** Again statewide average for these workers is around $16.50/hour

CMHA OPPOSES ANY NEW LEGISLATIVE MANDATED RATE INCREASE FOR A SPECIFIC SERVICE THAT INTERFERES WITH PIHPS AND CMHSPS REQUIREMENT TO ESTABLISH FAIR MARKET RATES

- Recently, the legislature has increased rates for ABA autism services and methadone reimbursements. CMHA supports adjusting rates and increasing funding levels overall, which then give our members maximum flexibility on how best to use those funds within their communities and allows them to negotiate fair markets rates with their providers.

REDUCE ADMINISTRATIVE BURDENS

We are requesting the **addition of boilerplate language that would ELIMINATE / REDUCE a number of administrative burden on the public mental health system**.

1. **Suggested boilerplate on Deemed Status – to reduce the number of non-value added audits and reports**

DHHS shall waive all reviews and audits for CMHs and provider organizations that have received full accreditation from a qualifying national accrediting entity for those program and financial reviews that were included during the national accreditation process.

- Tremendous amount of duplication and redundancy in state program/financial reviews and audits. There should be oversight of the system, but we want to eliminate the duplication and non-value added requirements.

- Ohio and Illinois both have deemed status Illinois found there was 40% redundancy between state requirements and national accreditation requirements

    - CMHA members (PIHPs/CMHs/Providers) spend thousands of staff hours and resources complying with state reviews that do not provide value, are not used in a substantive manner or are duplicative.

2. **Reduce clinical and contractual paperwork demands and reverse the recent explosion in the number of procedure codes required of the community-based system:** Two developments on this front are in immediate attention:

    - MDHHS and Milliman-led move to 15-minute codes for community living supports (CLS) vs 1 report per day – **change resulted in 96 reports per day vs 1.**

- MDHHS and Milliman-led dramatic increase in service code combinations – the complexity and burden on the clinicians and other service delivery staff, finance, and information technology staff of the community-based system have grown exponentially, 7,169 combinations of unit costs that must reported by the community-based system.

MEDICAID INMATE REENTRY PROGRAM

- **Support** the FY26 Executive Budget recommendation to include $40 million for the community reentry of incarcerated individuals ($20 million general fund) to provide coverage starting 90 days before an individual's scheduled release.
    - This will allow for health screenings and other services prior to reentry to identify key health needs and social determinants to facilitate a successful transition. Investing in these transition services will help improve health outcomes and access to community services, all of which will reduce recidivism.

MEDICAID RATES MUST REFLECT REALISTIC INPATIENT HOSPITAL COSTS

- Inpatient hospital rates continue to rise and range from $827 - $1250 / per day. Most inpatient psych hospitals exceed $1000/day with the average community inpatient rate close to $1100/day. Costs for inpatient hospital care has gone up by over 25% in one year. The statewide Medicaid paid average rate for inpatient hospital care is around $835 / per day.
    - Medicaid rates must also reflect the higher levels of community inpatient use given the lack of access to state hospitals.
    - Many PIHPs are losing millions of dollars a year on inpatient hospital care.

BOILERPLATE SUGGESTIONS

PIHP Reserves

The Michigan Department of Health and Human Services shall allow each Prepaid Inpatient Health Plans (PIHPs) to hold an actuarially sound amount in its Internal Service Funds (ISF) as determined based on its own experience, expenses, capital and surplus in relation to the benefits it will be obligated to provide.

PIHP Funding Formula – Geographic Factors

The Michigan Department of Health and Human Services shall revise the entity-specific factors (geographic factors) used to set Prepaid Inpatient Health Plans (PIHP) specific rates in order to more accurately reflect the factors that result in the variation in Medicaid behavioral healthcare costs in PIHP regions across the state.

Allow CMHs to retain Medicaid savings

The department shall allow CMHSPs to retain any Medicaid savings that they generate through efficiencies and effective clinical practices with a portion of these savings to be provided, by the CMHSP where a CMHSP is a member of a regional PIHP, to the PIHP in their region for the funding of a region-wide risk pool.

(These savings, permitted for any other healthcare provider, would allow the CMHs to invest in meeting community needs and ensuring their clinical and fiscal stability.)

CLS self-determination rates cannot exceed provider rates

The department shall set a policy that prohibits rates for Community Living Supports through self-determination and self-directed arrangements shall not exceed the organization provider rates for that same service.

EVV requirement for Self-Determination

The department shall require that employees delivering Community Living Supports through self-determination and self-directed arrangements shall be required to meet the same Electronic Visit Verification (EVV) requirements and standards as other employees providing the same Community Living Supports services through an organization or agency are required.

Community Mental Health Association of Michigan - Comparison of Executive Budget to Actual Funding Available through the Capitation Funding Process for the 2023 through 2025 Fiscal Years

Capitated Funding Summary for FY2023	Enacted Budget	Initial Actuarial Certification Budget	Adjusted Actuarial Projected Budget	Actual Funding Available	Difference In Enacted Budget and Actual Funding Available	Percentage of Enacted Budget Available
Autism services	$ 292,562,600	$ 270,000,000	$ 247,500,000	$ 248,921,557	$ (43,641,043)	
Healthy Michigan plan - behavioral health	$ 570,067,600	$ 643,200,000	$ 449,775,000	$ 455,782,181	$ (114,285,419)	
Medicaid mental health services	$ 3,044,743,000	$ 3,003,500,000	$ 2,977,898,772	$ 2,961,204,524	$ (83,538,476)	
Medicaid substance use disorder services	$ 94,321,800	$ 88,400,000	$ 88,600,000	$ 88,867,174	$ (5,454,626)	
Totals:	**$ 4,001,695,000**	**$ 4,005,100,000**	**$ 3,763,773,772**	**$ 3,754,775,436**	**$ (246,919,564)**	**93.8%**

Capitated Funding Summary for FY2024	Enacted Budget	Initial Actuarial Certification Budget	Adjusted Actuarial Projected Budget	Actual Funding Available	Difference In Enacted Budget and Actual Funding Available	Percentage of Enacted Budget Available
Autism services	$ 279,257,100	$ 311,900,000	$ 309,230,000	$ 313,093,115	$ 33,836,015	
Healthy Michigan plan - behavioral health	$ 590,860,800	$ 436,400,000	$ 429,940,000	$ 465,258,316	$ (125,602,484)	
Medicaid mental health services	$ 3,160,958,400	$ 3,211,600,000	$ 3,168,070,000	$ 3,123,485,893	$ (37,472,507)	
Medicaid substance use disorder services	$ 95,264,000	$ 90,500,000	$ 88,700,000	$ 86,909,705	$ (8,354,295)	
Totals:	**$ 4,126,340,300**	**$ 4,050,400,000**	**$ 3,995,940,000**	**$ 3,988,747,030**	**$ (137,593,270)**	**96.7%**

Capitated Funding Summary for FY2025	Enacted Budget	Initial Actuarial Certification Budget	Adjusted Actuarial Projected Budget	Annualized Trend of Funding Available using October through January Actual	Difference in Enacted Budget and Trended Funding Available	Projected Percentage of Enacted Budget Available
Autism services	$ 329,620,000	$ 395,500,000	$ 395,500,000	$ 392,752,449	$ 63,132,449	
Healthy Michigan plan - behavioral health	$ 527,784,600	$ 464,300,000	$ 464,300,000	$ 456,723,777	$ (71,060,823)	
Medicaid mental health services	$ 3,387,066,600	$ 3,222,800,000	$ 3,222,800,000	$ 3,170,578,128	$ (216,488,472)	
Medicaid substance use disorder services	$ 95,650,100	$ 89,500,000	$ 89,500,000	$ 87,381,800	$ (8,268,300)	
Totals:	**$ 4,340,121,300**	**$ 4,172,100,000**	**$ 4,172,100,000**	**$ 4,107,436,154**	**$ (232,685,146)**	**94.6%**

Community Mental Health Association of Michigan

Waskul Settlement

WHAT ARE COMMUNITY LIVING SUPPORTS (CLS)?

Community Living Supports are used to increase or maintain personal self-sufficiency, facilitating an individual's achievement of his goals of community inclusion and participation, independence or productivity. The supports may be provided in the participant's residence or in community settings (including, but not limited to, libraries, city pools, camps, etc.).

Coverage includes:

- Assisting, reminding, observing, guiding and/or training in the following activities:
  - meal preparation
  - laundry
  - routine, seasonal, and heavy household care and maintenance
  - activities of daily living (e.g., bathing, eating, dressing, personal hygiene)
  - shopping for food and other necessities of daily living

The majority of individuals receive their community living supports through an agency or provider, however some families and individuals choose a self determination/self-directed budget arrangement which allows them the freedom to hire staff of their choosing to provide needed services and supports.

Regardless of how the CLS service is provided (e.g., agency / provider or self-directed), the same pool of Direct Care Workers provide that service. This pool of workers also provides other critical behavioral health services and services to aging populations.

WASKUL BACKGROUND

This suit was brought by a group of plaintiffs against the State of Michigan (MDHHS), the CMH Partnership of Southeast Michigan (the public Prepaid Inpatient Health Plan serving Washtenaw and surrounding counties), and Washtenaw County Community Mental Health.

The plaintiffs contend that the dollars provided to these plaintiffs, as part of a Self Determination/Self-Directed Budget arrangement, are insufficient to recruit and retain Direct Care Workers, providing Community Living Supports (CLS), to support the plaintiffs in their homes and community.

SETTLEMENT REACHED

On December 1, 2023, a signed settlement agreement between Plaintiffs and Defendant MDHHS was filed with the Court.

- The plaintiffs were receiving $21/hour to hire staff to provide CLS services for their loved ones. (average Direct Care Workers earns around $16.50/hour)

- **What the lawsuit ordered:**
    - **50% funding increase:** A minimum $31 per service hour rate for all self-determination CLS recipients served by Michigan's Habilitation Supports Waiver is **estimated to exceed $100 million over 5 years**, even without taking into account additional agreed upon expenditures for Overnight Health and Safety Supports
        - There are over 110,000 direct workers serving people who receive these CLS services that would include the direct care workers in the aging world.
        - **Those included in Waskul settlement make up only 7% of this larger group doing the same work.**

NEXT STEPS – CMS APPROVAL & FUNDING

- In order for this agreement to go into effect:

    - CMS must approve
        - CMS must approve the state's amendments to the Habilitation Supports Waiver (HSW)
        - The agreement as written would appear to create **two different classes** for HSW CLS services – one done by an agency/provider and one through a self-determination arrangement
            - Even though there is no discernible difference in the specific duties and responsibilities of the job.
    - The Michigan LEGISLATURE MUST APPROPRIATE THE FUNDS EACH YEAR
    - PIHPS must sign a contract (5 of the 10 PIHPS have NOT)

ISSUES THAT ARRISE FROM THE SETTLEMENT

Waste

- The mandated $31 / hour rate is more than double what some areas of the State need to provide the services

Fairness

- Settlement only impacts those direct care workers providing Community Living Support (CLS) services for those individuals on the Habilitation Supports Waiver and that have a self-determination arrangement.
    - 17% of individuals receiving CLS services are on the Habilitation Supports Waiver

- The agreement **creates two different classes for HSW CLS services** – one done by an agency/provider and one through a self-determination arrangement
  - Same service, same worker, same Medicaid waiver; one winner and one loser
  - Lots of other people also lose out, including aging populations and job training services

Financial Impact

- MDHHS agreed to over $100 million in additional spending, assuming implementation by the start of Fiscal Year 2025 in October 2024. This does not account for the additional agreed upon expenditures for Overnight Health and Safety Supports.

- **Same plaintiffs' attorneys have sued to expand this to all direct care workers. This has the potential to cost the state of Michigan between $1 – 2 BILLION.**
  - **For every $1/hour you increase direct care workers (50,000 in public mental health system and 50,000 in long term care) it costs the state over $200 million.** Again statewide average for these workers is around $16.50/hour

Ask:

Just throwing money at a problem creates more problems. Need smart government and systemic solution, both of which MDHHS has refused to discuss

1. **Ask CMS to withhold approval of waiver amendments.**
2. **Condition any additional funding on systemic solution.**

Impacts of Medicaid Redetermination

on Michigan's Public Mental Health System

CMHA Community Mental Health Association of Michigan

Medicaid disenrollment patterns deeper and steeper than predicted

Medicaid redetermination presents a fundamental financing issue for the Community Mental Health Association of Michigan and its members that provide public mental health services throughout Michigan. During the COVID-19 public health emergency, Medicaid redetermination was frozen – resulting in an increase in Medicaid recipients throughout the state. With the redetermination process reinstated in 2023, it is anticipated that hundreds of thousands of recipients will lose their Medicaid coverage, causing a ripple effect on the public mental health system through decreased funding to providers.

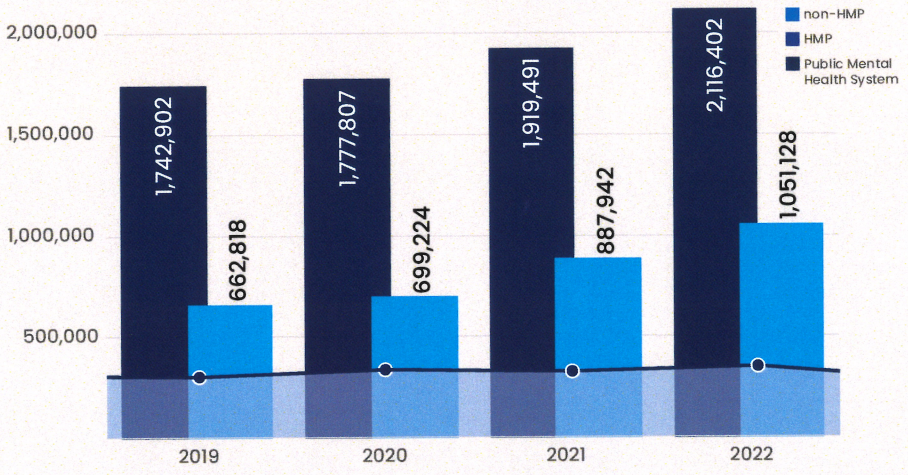
How CMH/PIHPs are paid

Public mental health providers receive payment through capitation payments. **Capitation payments** are fixed monthly allocation provided to a medical provider through a state or private health plan – simply put, the more people enrolled means more overall financial support being allocated to the mental health services. **These payments are paid monthly to providers for each member enrolled in the health care plan no matter how many times the member utilizes services.** Increased enrollment in the Medicaid system throughout the public health emergency boosted budgets allowing for increased services and better mental health support throughout the state.

Public mental health system usage

The number of persons served by Michigan's public mental health system does not fluctuate as overall Medicaid enrollment goes up or down. The vast majority of consumption within our public mental health system is by two groups – the serious and persistently mentally ill population as well as the intellectually developmentally disabled population. Overall, the public mental health system consistently serves 300,000-350,000 persons annually.

Average Medicaid and Healthy Michigan Plan (HMP) Enrollment



Medicaid Rate Variable Issues

1

Due to the expected drop in Medicaid enrollees, public mental health funding is anticipated to drop significantly throughout the state. Current trends indicate that the drop-off is happening at an even faster rate than originally projected.

2

Medicaid rates have not kept up with inflation. The adjusted consumer price index has gone up nearly 19% over the past three years which has greatly outpaced any increases in overall Medicaid rates during that time. Additionally, FY24 rates did not reflect increased wages required to close workforce gaps (increased wages, signing bonuses and provider costs that were required in FY23, but are still needed to recruit and retain staff in the future).

3

Incorrect Medicaid bucket slotting will cause additional stress on the mental health system. During the redetermination process, enrollees are assigned into a Medicaid bucket that determines their funding allocation. Currently the state's PIHPs and CMSHPs are experiencing ineffective re-enrollment determination patterns causing many enrollees to be incorrectly assigned.

4

The financial impact of incorrect slotting is detrimental. Using the example above, reimbursement rates of the different buckets provide a snapshot into the impact of incorrect slotting at redetermination:

1. **Disable Aged Blind (DAB)**
   $378.32/per person per month
2. **Temporary Assistance for Needy Families (TANF)** $34.58/per person per month
3. **Health MI (HMP)**
   $42.46/per person per month

Our members conducted a study that showed nearly 42,000 individuals in FY16 & FY17 categorized as Disabled, Aged, and Blind (DAB) moved to Healthy Michigan Plan (HMP) & Temporary Assistance for Needy Families (TANF) programs during the Medicaid redetermination process. This change in enrollment has resulted in nearly $100 million in lost revenue to our PIHP/CMH system.

Our Asks

> Adjust Medicaid rates to offset disenrollment patterns and to accurately account for the necessary staffing adjustments and provider costs increases.

> Ensure that enrollees are slotted into the correct Medicaid bucket to properly empower providers to deliver needed services.

CMHA
Community Mental Health Association of Michigan

The Community Mental Health Association of Michigan is the state association representing Michigan's public Community Mental Health (CMH) centers, the public Prepaid Inpatient Health Plans (PIHP – public health plans formed and governed by CMH centers) and the private providers within the CMH and PIHP provider networks.

FOR MORE INFORMATION, PLEASE VISIT CMHA.ORG OR CALL 517-347-6848.

CMHAM.org /CMHAMich @CMHAMich

Community Mental Health Association of Michigan

Outcomes from Michigan CCBHC Demonstration Sites

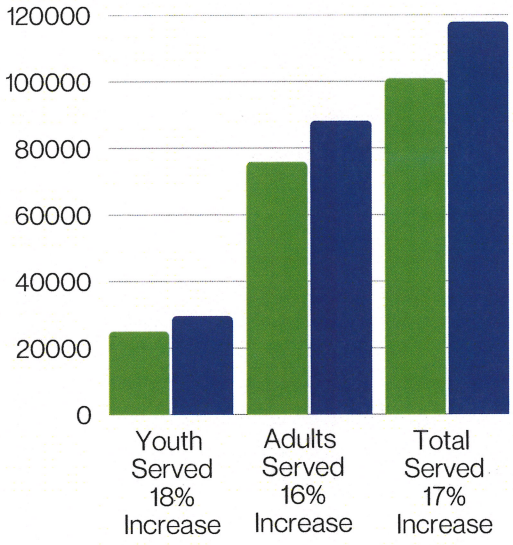
DATA FROM FY24

CCBHC strengthens the public safety net in CCBHC communities across Michigan, helping every person live their best life.

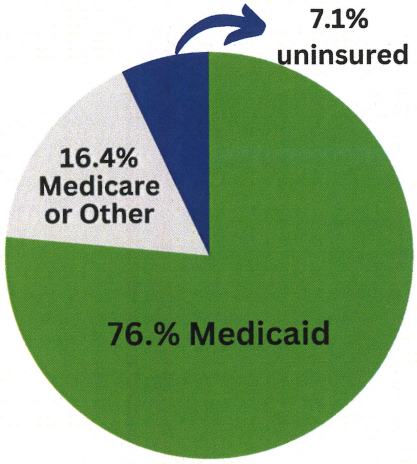
IMPROVED ACCESS TO BEHAVIORAL HEALTH SERVICES

An increase in number of youth and adults served, increased services to Mild to Moderate population, and expansion of same day access and crisis services.

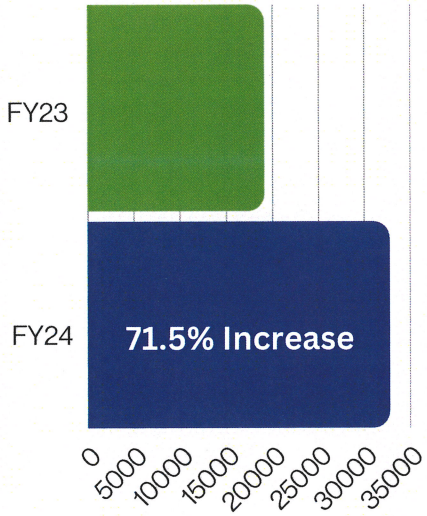
Number of individuals served in 2023 (green) versus 2024 (blue)



Individuals Served by Insurance Type



Number of individuals served with Mild to Moderate



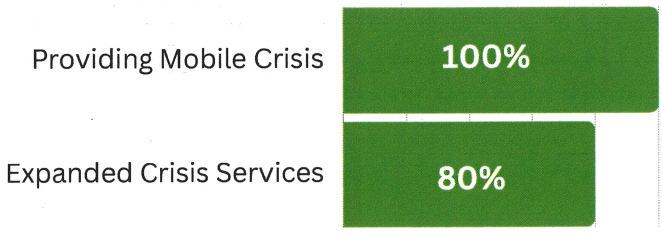
100% CCBHCs offering Same Day Access, up 5% from 2023

CCBHCs offering school based services

CCBHCs with expanded SUD services

EXPANSION OF CRISIS RESPONSE SERVICES

CCBHCs are all providing mobile crisis services and many have added staff, services or implemented creative strategies to address mobile crisis staffing challenges.

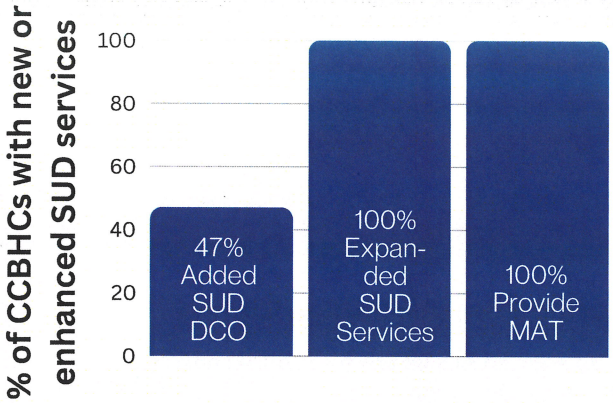


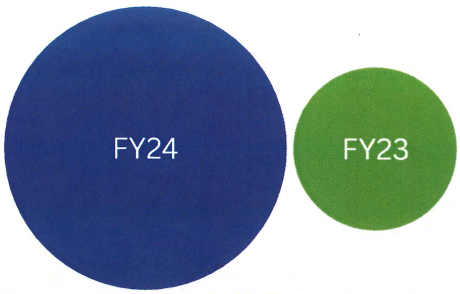
INNOVATIVE PRACTICES REPORTED:

- Staffing mobile crisis services can often be challenging, some CCBHCs have found creative solutions, partnering with DCOs or other partner agencies to meet this need.
- Several CCBHCs are in the planning or implementation stage of establishing a Behavioral Health Urgent Care.
- Triaging crisis calls has helped one CCHBC who arranges a next day appointment for non-emergency callers.

IMPROVED ACCESS TO SUD SERVICES

MAT is now offered at 100% of clinics and every clinic expanded access in 2024. There's been a 202% increase in provision of MAT services since 2023.

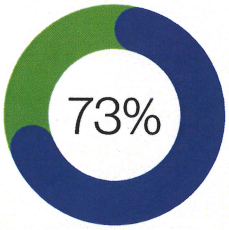




202% Increase in number of individuals receiving MAT

IMPROVED COLLABORATION WITH LAW ENFORCEMENT

Many CCBHCs collaborate with law enforcement via a CIT model or similar training and partnership.



CCBHCs that provide a Crisis Intervention Team (CIT) or similar

Majority of CCBHCs reported embedding clinicians in the jail or within police departments. Including creative use of technology to virtually connect clinicians at the scene.

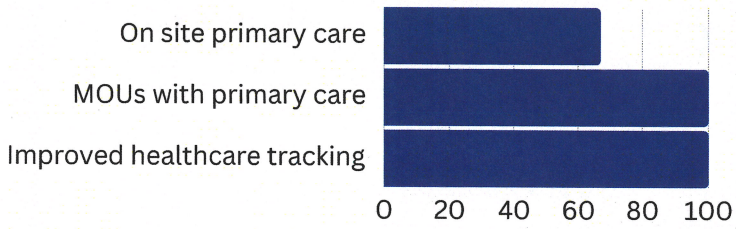
INNOVATIVE PRACTICES REPORTED:

- Publication of "Jail Diversion Field Guide" to help community partners understand options at each point of contact in our legal system.
- Sequential Intercept Mapping Event bringing together law enforcement, behavioral & physical health, local leaders and community members to strengthen crisis response system.
- Referring 1,100 individuals to behavioral health services via law enforcement and use of specialty courts like drug court, mental health court, veterans court, etc.

IMPROVED ACCESS TO PRIMARY CARE

with more than half of CCBHCs providing on-site care and 100% having MOUs with primary care and improved health tracking.

% of CCBHCs with expanded access to primary care



ADDRESSING SOCIAL DETERMINANTS OF HEALTH

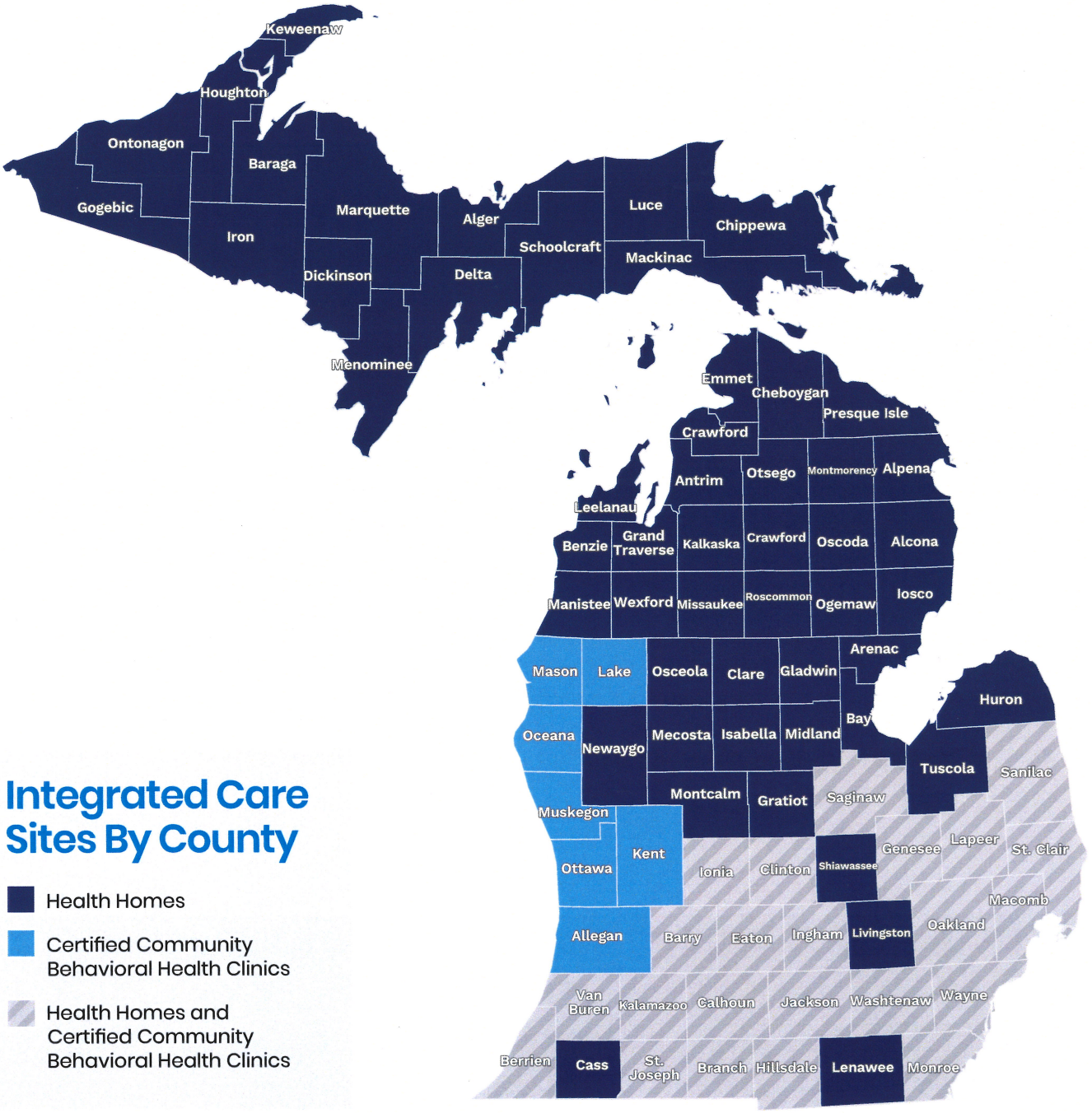
using standardized screening tools and improved data tracking implemented across CCBHCs.

More than half of CCBHCs use the Accountable Health Communities Health-Related Social Needs (AHC-HRSN) Screening Tool.

They have reported success in helping individuals address food insecurities, transportation barriers, educational attainment, smoking cessation and housing stability.

Innovative Integrated Care Across Michigan

The state of Michigan has a wide range of innovative integrative care sites including **Certified Community Behavioral Health Clinics** (CCBHC) and **Health Homes** (Behavioral and/or Opioid Health Homes). These innovative integrated care sites throughout the state ensure that those in need of service have access to the treatment they need. The attached map displays the services available in each county in Michigan.



Integrated Care Sites By County

- Health Homes
- Certified Community Behavioral Health Clinics
- Health Homes and Certified Community Behavioral Health Clinics

Types of Integrated Care Sites

CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS

CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS (CCBHC) demonstrations aim to improve the behavioral health for all Michiganders by: (1) increasing access to high-quality care, (2) coordinating integrated behavioral health with physical health care, (3) promoting the use of evidence-based practices, and (4) establishing standardization and consistency with a set criterion for all certified clinics to follow.

The CCBHC model requires access to 24/7/365 crisis response services, along with other critical elements including strong financial and quality metric reporting; formal coordination with primary and other care settings to provide intensive care management and transitions of care; linkage to social services, criminal justice/law enforcement, and educational systems.

CCBHC clinics are designed to provide a broad array of mental health and substance use disorder services to persons of all ages, regardless of ability to pay, including those who are underserved, have low incomes, have Medicaid, are privately insured or uninsured, and are active-duty military or veterans.

HEALTH HOMES

There are two types of health homes: Behavioral Health Homes and Opioid Health Homes. Health homes receive reimbursement for providing the following federally mandated core services:

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support
- Referral to Community and Social Services

BEHAVIORAL HEALTH HOMES (BHH) will provide comprehensive care management and coordination services to Medicaid beneficiaries with a serious mental illness or serious emotional disturbance. For enrolled beneficiaries, the BHH will function as the central point of contact for directing patient-centered care across the broader health care system. Beneficiaries will work with an interdisciplinary team of providers to develop a person-centered health action plan to best manage their care. The model will also elevate the role and importance of Peer Support Specialists and Community Health Workers to foster direct empathy and raise overall health and wellness. In doing so, this will attend to a beneficiary's complete health and social needs. Participation is voluntary and enrolled beneficiaries may opt-out at any time.

OPIOID HEALTH HOMES (OHH) will provide comprehensive care management and coordination services to Medicaid beneficiaries with opioid use disorder. For enrolled beneficiaries, the OHH will function as the central point of contact for directing patient-centered care across the broader health care system. Beneficiaries will work with an interdisciplinary team of providers to develop an individualized recovery care plan to best manage their care. The model will also elevate the role and importance of peer recovery coaches and community health workers to foster direct empathy and connection to improve overall health and wellness. In doing so, this will attend to a beneficiary's complete health and social needs. Participation is voluntary, and enrolled beneficiaries may opt out at any time.

CMHA
Community Mental Health Association of Michigan

The Community Mental Health Association of Michigan is the state association representing Michigan's public Community Mental Health (CMH) centers, the public Prepaid Inpatient Health Plans (PIHP – public health plans formed and governed by CMH centers) and the private providers within the CMH and PIHP provider networks.

FOR MORE INFORMATION, PLEASE VISIT CMHA.ORG OR CALL 517-347-6848.

CMHAM.org /CMHAMich @CMHAMich

Minimizing Complexities

Meeting Federal Conflict Free Requirements in Ways That Promote Simplicity and Access to Care

The Michigan Department of Health and Human Services (MDHHS) recently proposed new requirements for individuals seeking mental health services through the public mental health system. While the new requirements would comply more directly with federal Conflict-Free Access and Planning (CFA&P) guidelines, they would create access challenges for those seeking care, service delays and additional costs to providers.

What is Conflict-Free Access and Planning?

CFAP is based on a 2014 federal requirement for Home and Community-Based Services (HCBS), a type of Medicaid service, which attempted to limit perceived conflicts of interest for beneficiaries obtaining HCBS. In Michigan, agencies can have more than one role: access, plan development, and service delivery. If one agency is helping an individual access and plan their services it is key to ensure that a conflict of interest does not exist and that persons served/clients/consumers have a choice of providers. A conflict of interest happens when a professional uses their role to benefit themselves or their employer.

CMHA and our members fully support the intent to limit conflicts, however we believe the proposed "solutions" outlined by MDHHS cause unnecessary disruption and complexity and provide a greater threat than the conflicts they are attempting to prevent.

APPROACH PROPOSED BY MDHHS

Requires you to go to one "provider" for assestment, planning, and case management, and another "provider" to receive services. If you change your service plan, you must go back to the planning "provider."

MICHIGAN'S CURRENT COMMUNITY MENTAL HEALTH-BASED MODEL

Allows a 1-stop shop for people to do an assestment, planning, case management and receive services.

Concerns with MDHHS Conflict-Free Proposal

1. The MDHHS proposal makes an already complex system more complex: Same day service would be impossible under the separation of functions that MDHHS is proposing. Outreach to persons, school children, homeless, would be seriously hindered by prohibiting the services provider from assessing and building a treatment/services plan with the person in need.
2. Persons served/clients/consumers are concerned with the MDHHS proposal: The comments of persons served (clients/consumers), obtained during the MDHHS listening sessions underscore their concerns with the MDHHS proposal:
    - "I think [separating access/planning from direct service] could be problematic due to a person having to repeat providing their info..."
    - "Having to go from here, to here, to here...to do it when being in a place where I need help would be a lot. It's a lot to ask one person to go through."

    - "Between the point of access and referral, things get dropped and lost."
3. The MDHHS proposal is in conflict with state law and other federal requirements:
    - The statutorily required core functions of Michigan's CMHs.
    - The federally required core functions of Michigan's Certified Community Behavioral Health Clinics (CCBHC) and Behavioral Health Homes (BHH)

DISADVANTAGES OF MDHHS' PROPOSED APPROACH

- Delays service delivery
- Increases costs
- Increases administrative burden
- Adds confusion and barriers for people served

CMHA-Recommended Process

Rather than add complexity to the system, Michigan can build upon the conflict mitigation approaches that already have the approval of the Federal Government.

There are a number of alternate approaches that Michigan could use to meet the federal Conflict-Free standards. One of those alternate approaches is:

1. Because it is not known until the assessment and Individual Plan of Service (IPOS) are completed, whether the person is in need of Home and Community-Based Services (HCBS), the initial assessment and Plan of Service should be carried out as it is now, by the CMHSP or their designated assessment and planning organization.
2. If HCBS are part of a person's Plan of Service, the person is presented with a list of organizations which provide those HCBS services, from which to choose. The organization carrying out the assessment and Plan of Service cannot be on that list unless that organization is the only organization who can provide that service.

Continue to strengthen the structural conflict mitigation components approved by the Federal Government

a. Persons facilitating the Person-Centered Planning (PCP) process cannot be providers of any HCBS to those with whom they facilitate PCP processes.

b. The person facilitating the PCP process or serving as the case manager/supports coordinator for the person served cannot authorize the services contained in the plan for that person.

c. Neither the persons facilitating the PCP process nor the providers of any HCBS can be the person responsible for the independent HCBS eligibility determination. This latter role is held by MDHHS.

This process is nested in a robust monitoring and contract compliance process.

Accessible, frequent, and readily-available information to persons served regarding the rights outlined above – through the use of:

(1) A uniform set of hard-copy handouts and electronic messages; (2) Notices on the websites of the state's CMHSPs, PIHPs, providers, and MDHHS; (3) Social media posts

Continual education, training, supervision, and coaching of CMHSP, PIHP, and provider staff around these rights – efforts led by MDHHS, the state's major advocacy organizations, and CMHA.

The use of contractual powers, corrective action plans, and sanctions, when needed, to ensure that these rights are afforded persons served – via the MDHHS/PIHP contract, the MDHHS/CMHSP contract, and the PIHP/CMHSP contract.

CMHA Community Mental Health Association of Michigan

The Community Mental Health Association of Michigan is the state association representing Michigan's public Community Mental Health (CMH) centers, the public Prepaid Inpatient Health Plans (PIHP – public health plans formed and governed by CMH centers) and the private providers within the CMH and PIHP provider networks.

FOR MORE INFORMATION, PLEASE VISIT CMHA.ORG OR CALL 517-347-6848.

CMHAM.org /CMHAMich @CMHAMich

The Detroit News
SERVING MICHIGAN SINCE 1873

OPINION *This piece expresses the views of its author(s), separate from those of this publication.*

Bolter: Collaborative approach to mental health in schools is needed

Alan Bolter The Detroit News

Published 8:01 p.m. ET Sept. 25, 2024 | **Updated 8:01 p.m. ET Sept. 25, 2024**

The recent passage of Michigan's FY 2025 budget has raised significant concerns by various school-based interest groups regarding substantial cuts in the mental health and school safety grants line item — dropping from a historic $491.8 million investment to $136.7 million, a 72% decrease from the previous year.

School groups argue this reduction threatens to undermine the progress these funds have made during the last several years in providing additional mental health resources for students. The Community Mental Health Association of Michigan (CMHA) shares these concerns. While all of us who are committed to the mental health of Michigan's children, youth and families are working to restore funding for both school-based and community-based mental health services, we must use this moment to rethink how we approach mental health care for students and how schools and community mental health organizations can work together to maximize limited resources.

The Community Mental Health Association of Michigan (CMHA) believes that we should act now to align school-based mental health resources and aims with those of Michigan's community-based public mental health system. By doing so, we can build a more cohesive, efficient and effective system of care for students across the state.

The concerns voiced by school groups in the wake of these budget cuts are valid. Districts worry that this reduction in funding threatens to lead to district-wide lay-offs of school resource officers and mental health professionals, potentially resulting in the loss of crucial security measures and student mental health resources. In the face of this loss, CMHA is underscoring its long-held belief that the solution lies not in isolated efforts but in a collaborative integrated approach — one that encourages all of Michigan's school districts, as

many have done, to partner with community mental health agencies and use their school-based mental health financing and related resources to contract for a range of mental health services from the state's community mental health system.

As many Michigan school districts have found, such partnerships leverage the expertise and infrastructure of these community-based mental health organizations to provide comprehensive and evidence-based services to students and their families. This approach benefits school services and enhances the existing framework of Michigan's mental health care system in its entirety.

While the recent cuts to mental health and safety funding in schools are a real loss of mental health resources focused on the needs of school-age Michiganians, the state's education and community mental health communities must take this opportunity to build a comprehensive system that covers both the school room and the community. The Community Mental Health Association (CMHA) is confident that with the right approach, we can, collectively, achieve strong outcomes for students and their families.

The debate over mental health funding in schools should not be centered on whether schools or community mental health systems receive the lion's share of resources. Instead, it should be about how we can break down the existing walls between schools and community mental health organizations, and build a more seamless, resilient system that serves all students more effectively.

As we continue to navigate these challenges of a rapidly evolving mental health landscape, it is essential that we advocate for a collaborative model of care that equally values both school-based services and community mental health resources. This approach not only addresses the immediate concerns arising from recent funding cuts but also provides an opportunity to build a more cohesive and resilient mental health system for the future.

Alan Bolter is associate director of the Community Mental Health Association of Michigan (CMHA)

MACOMB COUNTY COMMUNITY MENTAL HEALTH

Substance Use Engagement Center

24/7

A welcome addition for individuals with active substance use disorders.

WHAT IS THE ENGAGEMENT CENTER?

An Engagement Center is a short-term crisis intervention facility that provides a supervised, supportive setting for individuals with substance use disorders.

As an alternative to emergency room care or jail for an individual impaired from substance use, an Engagement Center serves individuals who require observation for safety in an appropriate setting.

Individuals are provided with a safe place to stay for a few hours or a day in a clean, welcoming environment. Individuals can stabilize, have a meal, take a shower, and talk to caring staff. Services are typically provided by Peer Recovery Coaches.

Individuals receive information on and assistance in obtaining treatment, funding, and referrals, as well as links to other recovery resources, housing, medical and other needed services.

WHO CAN RECEIVE SERVICES?

ELIGIBLE:

- Individuals actively using substances or under the influence
- Not a danger to self or others
- Willing to participate in Engagement Center Services

NOT ELIGIBLE:

- Individuals who require acute medical intervention
- Individuals who are medically unstable
- Evidence of injury within the last 48 hours
- Combative or reasonably believe they would be difficult for staff to control or observe
- Actively psychotic or experiencing thoughts of harm to self or others

GOALS

- Provide a community supervised, supportive setting for acutely intoxicated/impaired individuals.
- As an alternative to Hospital Emergency Room Care or jail, an Engagement Center is intended for those who require observation for safety in an appropriate setting, including sharing resources for recovery and treatment services.

HIGHLIGHTS

- Staff are trained direct care workers, many with recovery experience
- Supported by peers and medical professionals with recovery experience
- Available on a 24/7 basis
- Considered a 23 hour stay, but individuals may stay longer awaiting a transfer to treatment
- Average facility is six to twelve bed capacity

SERVICES PROVIDED

- Medical triage
- 24-hour bed check
- Vitals every 2 hours
- Oral rehydration and food service
- Shower and laundry
- Resources for substance use treatment
- Resources for health and behavioral health services
- Resources for homeless care support services as needed
- Introduction to Recovery Coaches and recovery community
- Development of a Recovery Plan

Macomb County Community Mental Health Administration,
19800 Hall Rd. Clinton Township MI, 48038 586-469-5278

MACOMB COUNTY COMMUNITY MENTAL HEALTH

Substance Use Engagement Center

24/7

A welcome addition for individuals with active substance use disorders.

WHAT IS THE ENGAGEMENT CENTER?

An Engagement Center is a short-term crisis intervention facility that provides a supervised, supportive setting for individuals with substance use disorders.

As an alternative to emergency room care or jail for an individual impaired from substance use, an Engagement Center serves individuals who require observation for safety in an appropriate setting.

Individuals are provided with a safe place to stay for a few hours or a day in a clean, welcoming environment. Individuals can stabilize, have a meal, take a shower, and talk to caring staff. Services are typically provided by Peer Recovery Coaches.

Individuals receive information on and assistance in obtaining treatment, funding, and referrals, as well as links to other recovery resources, housing, medical and other needed services.

WHO CAN RECEIVE SERVICES?

ELIGIBLE:

- Individuals actively using substances or under the influence
- Not a danger to self or others
- Willing to participate in Engagement Center Services

NOT ELIGIBLE:

- Individuals who require acute medical intervention
- Individuals who are medically unstable
- Evidence of injury within the last 48 hours
- Combative or reasonably believe they would be difficult for staff to control or observe
- Actively psychotic or experiencing thoughts of harm to self or others

GOALS

- Provide a community supervised, supportive setting for acutely intoxicated/impaired individuals.
- As an alternative to Hospital Emergency Room Care or jail, an Engagement Center is intended for those who require observation for safety in an appropriate setting, including sharing resources for recovery and treatment services.

HIGHLIGHTS

- Staff are trained direct care workers, many with recovery experience
- Supported by peers and medical professionals with recovery experience
- Available on a 24/7 basis
- Considered a 23 hour stay, but individuals may stay longer awaiting a transfer to treatment
- Average facility is six to twelve bed capacity

SERVICES PROVIDED

- Medical triage
- 24-hour bed check
- Vitals every 2 hours
- Oral rehydration and food service
- Shower and laundry
- Resources for substance use treatment
- Resources for health and behavioral health services
- Resources for homeless care support services as needed
- Introduction to Recovery Coaches and recovery community
- Development of a Recovery Plan

Macomb County Community Mental Health Administration,
19800 Hall Rd. Clinton Township MI, 48038 586-469-5278

MACOMB COUNTY COMMUNITY MENTAL HEALTH

MACOMB COUNTY 1818 MICHIGAN

ASPIRE to Excellence® carf ACCREDITED

MICHIGAN'S PUBLIC MENTAL HEALTH SYSTEM

Your Local Safety Net

Through both mission and contractual obligations community mental health agencies tie together essential community services with their unique role in the community as an "integrator" of services.

CMHSPs must work closely with local public and private community-based organizations and providers to address prevalent human conditions and issues that are related to a shared consumer base.

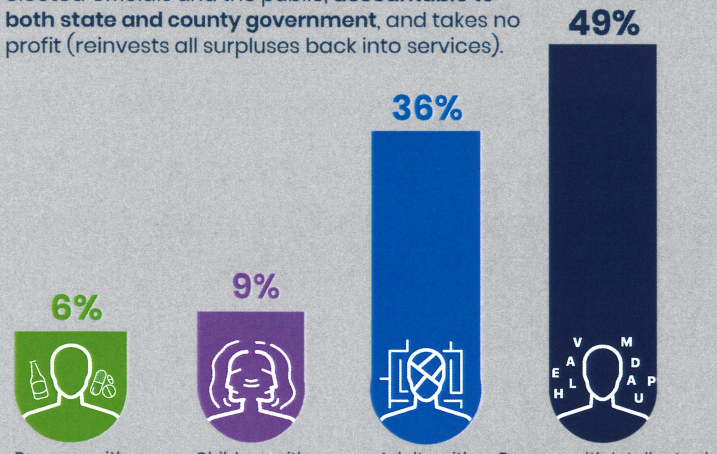
Local coordination and collaboration with these entities will make a wider range of essential supports and services available...CMHSPs are encouraged to coordinate with these entities through participation in multipurpose human service collaborative bodies and other similar community groups.

Who we serve and how the money is spent

Michigan's Public Mental Health System Serves 4 Main populations:

Michigan is the **ONLY** state that serves all 4 populations in a managed care setting.

The system is a public system, that is tied to local elected officials and the public, **accountable to both state and county government**, and takes no profit (reinvests all surpluses back into services).

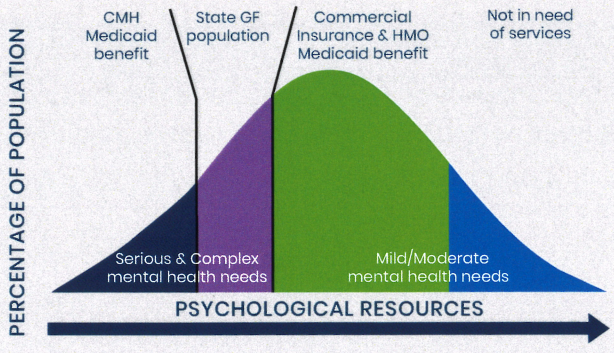


The CMH system serves the most in need population

1 in 5 people in the State of Michigan suffer from a mental illness.

That is 2M people total.

Of those 2 million people, Michigan's public mental health system serves the most serious and complex individuals, which is about **300,000 people.**



(Well-Being Institute, University of Cambridge, 2011)

CMHA Community Mental Health Association of Michigan

The Community Mental Health Association of Michigan is the state association representing Michigan's public Community Mental Health (CMH) centers, the public Prepaid Inpatient Health Plans (PIHP – public health plans formed and governed by CMH centers) and the private providers within the CMH and PIHP provider networks.

FOR MORE INFORMATION, PLEASE VISIT CMHA.ORG OR CALL 517-347-6848.

CMHAM.org /CMHAMich @CMHAMich

Did you Know?

83 counties in Michigan are covered by the 46 CMHs & 10 PIHPs.

94% medical loss ratio (i.e. the percentage of dollars spent on actual care) of Michigan's public PIHP system has a statewide average spent on administrative costs of 6%.

Since 1997, Michigan has remained the only state in the nation that provides publicly managed care for all four major populations; adults with mental illness, children and adolescents with emotional disturbances, persons with intellectual / developmental disabilities, and those with substance use disorders ***[saving the state more than $1 billion!]***

24 hours a day / 7 days a week, mental health professionals provide services for people with mental illness, intellectual / developmental disabilities, and substance use disorders regardless of ability to pay. As outlined in Michigan's Mental Health Code, Public Act 258 of 1974, Michigan's public mental health system serves as the local public safety net for the state's most vulnerable citizens.

91 percent of the CMH budget is from Medicaid and Healthy MI plan. State General dollars that serve people without insurance makes up only 4% of the total budget.

2 million people statewide are impacted by one of the 300,000 people served by Michigan's public community mental health system when you include family, friends, neighbors, and co-workers.

Michigan's public community mental health system is a ***$3 billion industry*** in our state employing more than ***100,000 people.***

750+ Michigan's CMH/PIHP system is leading the way with more than 750 on-the-ground healthcare integration initiatives across the state - co-location, electronic health records, and partnerships.

Substance Use Disorders

Opioid deaths in Michigan are increasing. From 1999 to 2016, the total number of ***overdose deaths involving any type of opioid increased more than 17 times in Michigan,*** from 99 to 1,689.3 ***Over six people in Michigan die every day from opioid-related causes.***

Every person can make a difference. Some things you can start doing today:

- Store medications safely.
- Don't share prescription medications.
- Learn to recognize the signs and symptoms of opioid abuse.
- Keep talking about the opioid epidemic and help break the stigma.

Healthy Michigan Plan provides dedicated and reliable funding for persons with substance use disorders and who have co-occurring mild to moderate mental disorders.

Prior to HMP (Medicaid Expansion), some regions had up to six month waiting lists for Medication Assisted Treatment (MAT) or withdrawal management /residential treatment. Oftentimes these are the most important services for people with opiate use disorders to begin the road to recovery.

Over 70,000 people receive Substance Use Disorder treatment and recovery services through Michigan's public system each year.

Testimony to Michigan House Medicaid and Behavioral Health Appropriations Subcommittee March 11. 2025

The Honorable Greg VanWoerkom, Chairperson

Bradley P. Casemore CEO Southwest Michigan Behavioral Health (SWMBH)

Greetings Chairperson VanWoerkom and Committee Members, thank you for permitting me to testify this morning. I am Bradley Casemore CEO Southwest Michigan Behavioral Health one of Michigan's ten Prepaid Inpatient Health Plans teaming with eight Community Mental Health Service Programs providing Medicaid behavioral health services to nearly 20,000 persons annually.

I will focus today on just one issue – the underfunding of the public behavioral health system and the statewide elevated expense pressures. In our region this has resulted in financial circumstances threatening the ability to provide services come this fall when two of our CMHs develop a negative cash flow situation with the PIHP resources also depleted.

Multiple factors have contributed to this situation chief among them under-estimated Medicaid capitation revenues combined with elevated expenses over several years:

- Serious declines in Medicaid redeterminations, eligibles and related revenues to the system.
- Double digit inflation in healthcare staffing and other costs.
- Pent up previously existing and new need and demand that emerged and remains subsequent to the Public Health Emergency.
- Cessation of federal American Rescue Plan and other resource infusions during the Public Health Emergency period.
- The State's actuary Milliman readily admits that Medicaid capitation rates are actuarily sound at the State level, but not necessarily actuarially sound at PIHP levels. While MDHHS provided an 11% overall rate increase to the system in FY25, an analysis of Region 4's fiscal year 2024 October through January revenue to fiscal year 2025 reveals only a 3.4% increase.
- The number of individuals served by Region 4 has continued to increase 2025 over 2024 resulting in increased costs.
- MDHHS has shifted the cost of caring for individuals experiencing the most acute need closing and limiting admissions to the state hospitals. This has shifted the cost of care from General Fund to Medicaid in tens of millions of dollars state-wide and resulted in higher demand for community inpatient psychiatric hospitals at rates higher than state hospitals and with those rates still climbing.

- MDHHS – Milliman recently released a fiscal year 2025 Rate Amendment in order to implement the statutorily required $66 per hour autism service unit rate. That rate increase was not provided to the public behavioral health system until March 2025, even though it was effective November 2024. Analysis of those rates show them as insufficient to cover known historical volumes let alone ongoing additional service needs. Additionally we have yet to see rate consideration for the statutorily required minimum wage changes or paid sick leave. Such after-the-fact funding undermines the stability and survivability of the public behavioral health provider system.

We have provided a detailed analysis of the drivers of revenue shortfalls and elevated expenses to the Committee in hard copy and electronically to Committee staff.

The Prepaid Inpatient Health Plans operate under a shared risk arrangement with the state where PIHPs are limited to a 7.5 % Risk Reserve Fund. As seen with several PIHPs over the last ten years this cap is wholly inadequate and once the Fund is depleted there is no mechanism for replenishing it.

My region is $10 million into the state's risk corridor for the fiscal year ended September 30, 2024 with a projection for state risk corridor entry of $20 million for fiscal year 2025. We expect the state to honor its risk-sharing funding contractual obligations for this region and others. Medicaid eligibles are entitled to medically necessary services which cannot be suspended terminated or reduced for financial reasons.

Our region remains committed to and capable of providing access to quality effective supports and services.

My Ask today on behalf of the system and our region is

- Familiarize yourselves with the current status and projections for Medicaid behavioral health services and funding. Multiple regions are in dire financial straits.
- Assure adequate Medicaid and General Fund resources for behavioral health services for fiscal years 2025 and 2026.

Thank you again for permitting me to testify.

<END>

My name is John Ruddell and I'm here representing Woodlands Behavioral Healthcare Network of Cass County. Cass County is a rural county of approximately 50,000 residents in the Southwest corner of Michigan, right on the border with Indiana.

On average, 1,000 Cass County residents use our services that include outpatient therapy, autism therapy, crisis intervention, substance use disorders, and care coordination with other health services. We provide community living supports for our intellectually disabled residents. Also, in collaboration with our local law enforcements, we provide a 24-7 mobile crisis service that travels to the location of the crisis.

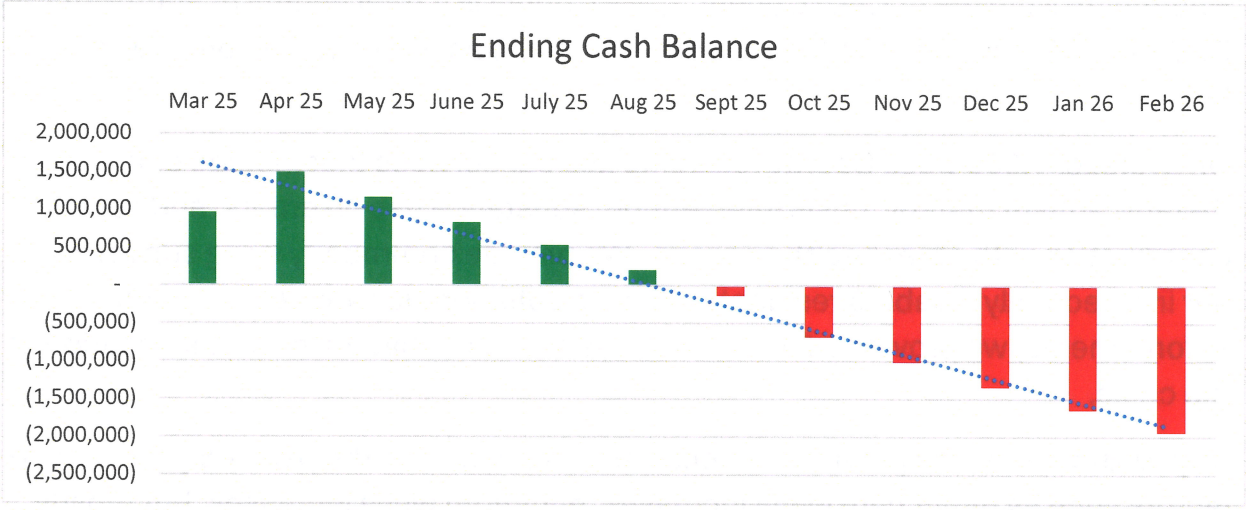
As you know, costs to provide services has increased over the past 4-5 years due to factors such as direct care wage increases, minimum wage increases, but mostly due to inflation. However, the calculation used by MDHHS to distribute Medicaid funds has lagged far behind the increase in costs.

Each year, we go through a cost settlement process with MDHHS to ensure that Medicaid revenues and expenses equal. In 2020, 2021, and 2022, Woodlands sent back millions of Medicaid dollars. However, costs have outpaced the increases in revenue and MDHHS owed us $4.5 million in FY 2024. Estimates for FY 2025 indicate that MDHHS will again owe Woodlands approximately $4 million in Medicaid dollars.

Woodlands' revenue is short $350,000 each month and we are not made whole until the following April. To balance our budget, Woodlands has reduced staff by 7% this year. We have applied for and received grants to increase revenue and cover services. The other area we are attempting to reduce costs is in consumer services that are not medically necessary. During each consumer's annual clinical review, if their condition does not require the service, then we are discontinuing or reducing the service.

Absent a drastic increase in revenue from MDHHS, Cass County residents will have their medically necessary and entitled Medicaid services drastically reduced or in some cases discontinued at the end of September 2025.

Neither Woodlands nor Cass County has $4 million available to cover costs until MDHHS performs the FY2025 cost settlement process. All I'm asking is that MDHHS adequately distribute the funds that the legislature has already appropriated.



Ask me about specialized residential consumers if the funding does not happen?

John Ruddell, Executive Director

johnr@woodlandsbhn.org

269-228-5130